# Authorization and Agreement for Electronic Direct Deposit of Producer Compensation

## Direct Deposit is Fast and Convenient

- Fits your busy schedule
- Address changes/mail will not delay payment
- Statements available online (up to 12 months)
- Trips to deposit your checks are eliminated

| **Part 1. Account Information** | | |
|---|---|---|
| Account Holder Name *(as it appears on the account)*: | | |
| Financial Institution: | | |
| Address: (of the Financial Institution) | | |
| City: | State: | Zip Code: |
| Phone *(including area code)*: | | |
| Email *(where you wish to receive commission statements)*: | | |
| Nine Digit Routing Number for Your Financial Institution: | | |
| Account Number: | **Note**: Please submit a voided check with this form | |
| IBAN Number *(for non-U.S. bank transfers)*: | SWIFT Number *(for non-U.S. bank transfers)*: | |

**Part 2. Authorization**

By completing and signing this form, I hereby authorize International Medical Group® and/or any affiliate company (collectively, "the Company") to electronically deposit (and the Financial Institution to accept) my future commissions, and other compensation payable in cash (collectively "Compensation"), into the account listed above. I understand the deposits will be based upon, and are subject to, the terms and conditions of my compensation agreement(s) with the Company, and that the amounts of the deposits will fluctuate. I also authorize adjustment of any deposit made in error.

I understand that the Company will make every effort to deposit Compensation on the same working day(s) of each month following each compensation cycle, but that the Company cannot and does not guarantee that will occur. I understand that the other compensation outside the standard cycle, depending upon its nature may not be payable or paid according to any schedule. I agree to hold the Company harmless for any charges or damages, direct or indirect, related to the amount of, or the timing of, the deposits or adjustments.

I agree to receive and to view my compensation statements solely via the Internet-based system(s) provided by the Company, and that by making them available in this manner, the Company satisfies any periodic statement and/or accounting obligations to me. I waive any claim to receive such statements in hard copy.

I understand that the company will make reasonable efforts to timely process this authorization or any changes to it, including revocation. However, I understand that such processing may not occur prior to the next deposit. I therefore agree that the prior compensation arrangements between us, if any, will continue until this authorization is processed. I agree to provide the Company immediate written notice of any change(s) in the information entered above. I acknowledge that bank fees charged to the Company can be deducted from my Compensation for account information which I have not kept current. I understand that any changes provided to the Company may not be implemented any sooner than 14 business days. Should I decide to revoke this authorization, I will provide both the Company and my Financial Institution advance written notice of revocation a minimum of 30 days prior to the day I seek such revocation to be effective.

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|---|---|
| Signature: | Date *(day/month/yr)*: |
| Printed Name: | Producer Number: |